TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS SURGICAL CENTER

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-17-1917-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim be paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,352.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2016	Ambulatory Surgical Care for CPT Code 26765-F9	$758.41	$758.41
	Ambulatory Surgical Care for CPT Code 11010-F9	$594.03	$293.66
TOTAL		$1,352.44	$1,052.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 144-Incentive adjustment, e.g. preferred product/service.
   - 59-Processed based on multiple or concurrent procedure rules.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for ambulatory surgical care center services rendered on August 16, 2016?

Findings

1. According to the explanation of benefits, the respondent paid $1,061.95 for CPT code 26765-F9 based upon the fee guideline. The requestor contends that additional reimbursement is due of $758.41 because the payment was not in accordance with the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement per the fee guideline.

   The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   28 Texas Administrative Code §134.402(f)(1)(A) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
   > (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent .

   According to Addendum AA, CPT code 26765 is a non-device intensive procedure.

   The Medicare ASC reimbursement rate for code 26765 CY 2016 is $813.76.

   The City wage index for Midland, Texas is 0.9196.

   To determine the geographically adjusted Medicare ASC reimbursement for code 26765, use the following formula:

   - The Medicare ASC reimbursement rate of $813.76 is divided by 2 = $406.88.
   - This number multiplied by the City Wage Index $163.61 X 0.9196 = $374.16.
   - Add these two together = $781.04.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $781.04 X 235% = $1,835.44. The respondent paid $1,061.95. The difference is $773.49. The requestor is seeking a lesser amount of $758.41; therefore, this amount is recommended.

2. According to the explanation of benefits, the respondent paid $300.37 for CPT code 11010-F9 based upon the fee guideline. The requestor contends that additional reimbursement is due of $594.03 because the

payment was not in accordance with the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement per the fee guideline.

The Medicare ASC reimbursement rate for code 11010-F9 CY 2016 is $526.74.

Using the above formula, the division finds the MAR is $1,188.06. Code 11010 is subject to multiple procedure discounting; therefore, $1,188.06 X 50% = $594.03. The respondent paid $300.37. As a result, additional reimbursement of $293.66 is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,052.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,052.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		3/23/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.